MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 434

0097i

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 25 yrs; Hospital, institution, or street address where death occurred: R.D. #2; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); Street No. R.D. #2 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eralina Baker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 7- 1862

8. AGE: Years	Months	Days	If less than one day
84	3	7	hrs. ..... min.

9. Birthplace Rockingham Co., Va. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Adam Baker; 13. Birthplace Rockingham Co. Va.

MOTHER — 14. Maiden name No. Record; 15. Birthplace

16. Informant Mr. William S. Brown; Address R.D. #2. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16-47 (month) (day) (year)

Cemetery or crematory Spring Hill Cem; Location Earlton Maryland

18. Funeral director Holloway & Co. Walter K. Holloway; Address Salisbury Maryland

19. 1/16-47 (Date rec'd by registrar) 19 W. Harris Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1947 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 1946 to Jan. 13 1947 and that I last saw h.. alive on Jan. 13 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William E. Nicols M. D. Other

Address Elbron - Md. Date signed Jan 15-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

00972

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da - 4 hrs - 50 mins. 20 years

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 5 days - 4 hrs - 50 mins

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 700 S. Division st. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Byrd Bertha Irene Byrd

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	divorced

6.(b) Name of husband or wife William Byrd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 4-1891

8. AGE: Years 53 - Months 0 Days 28 If less than one day ..... hrs. ..... min.

9. Birthplace Wilmington Delaware (Town, county, and state)

10. Usual occupation Beautician & owner

11. Industry or business Beauty shoppe

FATHER 12. Name John F. Coates

FATHER 13. Birthplace New Castle, Co. Del

MOTHER 14. Maiden name Nellie Eliza Morris

MOTHER 15. Birthplace R.D. Fruitland Md.

16. Informant Mr. Harold F. Coates

Address 700 S. Division st. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 5-47 (month) (day) (year)

Cemetery or crematory Fruitland Cemetery

Location Fruitland Md

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury maryland

19. 1/5 19 47 Received by registrar Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 19 47, at 4 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 19 46, to Jan. 2 19 47 and that I last saw h. alive on Jan. 2 19 47

Immediate cause of death	DURATION
Nephrosclerosis	Symptoms 3 years
Uremia	2 weeks
Due to Hypertension essential	Symptoms 10 yrs.
Due to	
Other conditions Hypertensive Heart Disease	Symptoms 6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David J. Gilmore M.D.
M. D. or other

Address 301 N. Division Salisbury, Md. Date signed Jan. 3, 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. And correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

00973

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 3 hrs 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Girdletree
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Marilyn Callick

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29 - 1946

8. AGE:

Years	Months	Days	If less than one day
	3	3	hrs. min.

9. Birthplace: Girdletree Worcester MD
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Charles Harmon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ernestine Callick
15. Birthplace: Maryland

16. Informant: G. Natty Callick
Address: Girdletree, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 24/47 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Girdletree Md

18. Funeral director: Edgar E. Dennis
Address: Snow Hill, Md

19. 1/24/47 (Date rec'd by registrar) 19... H. T. Harriel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1947 at 1 46 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Jan 1947 to 23 Jan 1947 and that I last saw her alive on 22 Jan 47 19...

Immediate cause of death	DURATION
Malnutrition, Pedatrophy - Pedatrophy	
Due to	3 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hermanda Ashby, M.D.
M. D. or other
Address: Snow Hill, Md Date signed: 24 Jan 47

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

00974

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Christopher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 1947

8. AGE: Years | Months | Days | If less than one day 5 hrs. 26 min.

9. Birthplace Salisbury, Wicomico, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Maycock, Walter

13. Birthplace Nassau, Bahamas

MOTHER 14. Maiden name Christopher, Mary Elizabeth

15. Birthplace Salisbury, Maryland

16. Informant

Address

17. ✓ Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 6 - 47 (month) (day) (year)

Cemetery or crematory Peninsula General Hospital

Location Salisbury, Maryland

18. Funeral director Peninsula General Hospital

Address Salisbury, Md.

19. 1/8/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1947, at M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clinton G. Insley M. D. or Other

Address Salisbury, Md. Date signed 1-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52 b

CERTIFICATE OF DEATH

06975

Reg. Dist. No. 3370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Jesterville md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Jesterville md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Thomas Levin Conway

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a.a.	Married

6.(b) Name of husband or wife: Lillie Conway

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): Jan 20 about 1893

8. AGE: Years: 53 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Jesterville md (Town, county, and state)

10. Usual occupation: School Bus Driver

11. Industry or business: Owner of School Buses

FATHER — 12. Name: Howard Conway

FATHER — 13. Birthplace: Jesterville Md

MOTHER — 14. Maiden name: Jennie Langford

MOTHER — 15. Birthplace: Quantico md

16. Informant: Lillie Conway

Address: Jesterville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7-1947 (month) (day) (year)

Cemetery or crematory: Jesterville

Location: Jesterville md

18. Funeral director: James H. Stewart

Address: Salisbury md

19. Jan 6 1947 (Date rec'd by registrar) Raleford Dellet Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3- 1947 at 10:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1946, to Jan 2 1947

and that I last saw h... alive on January 2 1947

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or other

Address: Salisbury - January 6-47 Date signed: 1/6/47

2-35

Dr. Finley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

06976

CERTIFICATE OF DEATH

Reg. Dist. No. 399

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution or street address where death occurred: Jenkins apt. Railroad Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Jenkins apt. Railroad Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mollie Dull Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: Gordon H. Cooper
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 27. 1868

8. AGE: Years: 78 | Months: 4 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: accomac Co. Virginia
(Town, county, and state)

10. Usual occupation: Home nurse

11. Industry or business: at Home

MOTHER FATHER

12. Name: John Dull
13. Birthplace: accomac Co. Va.

14. Maiden name: Mary
15. Birthplace: accomac Co. Va.

16. Informant: M. Gordon H. Cooper
Address: Jenkins apt. Railroad Ave. Salisbury Md

17. Burial
(Burial, cremation, or removal) (Which?) Date thereof Jan. 4-47 (month) (day) (year)

Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury maryland

19. 1-4-47 1947 Harriet D. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2nd 47 at 10.23 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Jan 2 1947
and that I last saw h.e alive on Jan 2 1947

Immediate cause of death	DURATION
Cardiovascular renal disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lewis A. Finley M. D. or other
Address: Salisbury Md Date signed 1-3-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

01045

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Fronnes on Wicomico River
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Wicomico Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Ezekiel Coulter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 14-1928

8. AGE: Years: 18 Months: Days: If less than one day: hrs. min.

9. Birthplace: Russell, N.C. (Town, county, and state)

10. Usual occupation: Presser at

11. Industry or business: Dry Cleaning Plant,

FATHER — 12. Name: Chas. S. Coulter

FATHER — 13. Birthplace: Gladstone, Ala.

MOTHER — 14. Maiden name: Etoy Jones

MOTHER — 15. Birthplace: Corinth, Miss.

16. Informant: Mrs. Etoy Coulter,

Address: 305 Wic. St. Salisbury, Md.

17. Burial, cremation, or removal. Which?: Buried Date thereof: May. 5-1947 (Month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Maryland,

19. (Date rec'd by registrar): 3/6-1947 Registrar: Harold C. Johnson Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: About Jan 18 1947 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on Examined April 19

	DURATION
Immediate cause of death: Drowning	Sudden death
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Jan 18, 1947

Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?): Wicomico River

Means of injury: Fell into river Injured at work? No

23. SIGNATURE: Dr. Rademaker M.D. Usual Medical Attendant

Address: Salisbury Md M. D. or other

Date signed: 3/4/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 - 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

00977

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year.

Hospital, Institution, or street address where death occurred:
105 Cherry Street.

How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Cherry St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Jane Cox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife William B. Cox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4, 1877

8. AGE: Years	Months	Days	If less than one day
70	10	19	..... hrs. ..... min.

9. Birthplace St. Luke, Worcester, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Ennis

13. Birthplace St. Luke, Md.

MOTHER 14. Maiden name Hettie S. Mullen

15. Birthplace St. Luke, Md.

16. Informant Howard Cox

Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/47 (month) (day) (year)

Cemetery or crematory Furness Cemetery

Location Nanticoke, Md.

18. Funeral director C. S. Messicks

Address Bivalve, Md.

19. 1/26, 1947 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1947, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22, 1947, to January 23, 1947 and that I last saw h.. alive on January 23 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to Chronic Cardio-Arterio Nephritis	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Joseph L. Valentine M.D.
M. D. or other

Address 742 N. Broadway Date signed 1/24/47
Baltimore, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 151

CERTIFICATE OF DEATH

00978

Reg. Dist. No. 339

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs - 40 mins

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 2 hrs - 40 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wic.

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route # 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Dickerson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
			2 hrs. 40 min.

9. Birthplace Salisbury, Wicomico, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Dickerson, William Bryan

13. Birthplace Bivalve, Md.

MOTHER 14. Maiden name White, Mary Lynne

15. Birthplace Allen, Md.

16. Informant

Address

17. Cremation Date thereof Jan. 27 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Peninsula General Hosp.

18. Funeral director

Address

19. 1/27 1947 Isaac E. Jones Local Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26 1947, to Jan. 26 1947

and that I last saw him alive on Jan. 26 1947

Immediate cause of death	DURATION
Respiratory Failure	
Due to Pneumonia (6 mo.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Stark M. D.

Address Salisbury Date signed 1-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

00979

Reg. Dist. No. 3390

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 years
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 9 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 1400 E. Main (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Vashti Dennis Dolle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Rudolph H. Dolle
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1896.

8. AGE: Years	Months	Days	If less than one day
50	11	16	..... hrs. ..... min.

9. Birthplace: Sussex Co., Delaware (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:

FATHER
12. Name: Alada Dennis
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Amanda Twilley
15. Birthplace: Wicomico Co., Md.

16. Informant: Rudolph H. Dolle
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury, Md.

18. Funeral director: E. Hill & Johnson Co.
Address: Salisbury, Md.

19. 1/21, 19 47. (Date rec'd by registrar) Carrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19, 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, 19..., to Jan. 19 1947
and that I last saw h[illegible] alive on Jan. 18 1947

Immediate cause of death: Acute subacular heart disease

DURATION
Approx

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other
Address: Salisbury Md. Date signed Jan 22

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00980 3330

Reg. Dist. No. 3330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert Junius Dulany

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1855

8. AGE: Years	Months	Days	If less than one day
91	4	25	... hrs. ... min.

9. Birthplace: Tony Tank, Wicomico Co., Maryland.
(Town, county, and state)

10. Usual occupation: Retied Store Keeper

11. Industry or business

FATHER
12. Name: I.H.A. Dulany
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Ann Marie White
15. Birthplace: Maryland.

16. Informant: Ralph O. Dulany
Address: Fruitland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/47 (month) (day) (year)

Cemetery or crematory: Fruitland Cemetery

Location: Fruitland, Maryland.

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Maryland.

19. 1/15, 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14 1947, at 4 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/28 1946, to 1/14 1947 and that I last saw h alive on 1/13 1947

Immediate cause of death	DURATION
Lobar Pneumonia	17 days
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Chas. T. Tilghman M.D.
M. D. or other

Address: Salisbury, Md. Date signed 1/15/47

2-35.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

*00981

Reg. Diat. No. 3890

1. PLACE OF DEATH:
County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, Institution, or street address where death occurred: Col. Green & Division streets
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Col. Green & Division sts.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Gilbert Folty

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Freddie Elizabeth Folty
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct. 7th 1880

8. AGE: Years: 66 | Months: 3 | Days: 11 | If less than one day: ....hrs. ....min.

9. Birthplace: Conicville Virginia
(Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business:

FATHER
12. Name: Charles Lemuel Folty
13. Birthplace: Conicville Virginia

MOTHER
14. Maiden name: Virginia Elizabeth Hill
15. Birthplace: Conicville Virginia

16. Informant: Miss Thelma Folty
Address: Fruitland Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20-1947 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Maryland

18. Funeral director: Walter R. Fellows
Address: Salisbury Maryland.

19. 1/20/47 (Date rec'd by registrar) 1947 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18th 1947 at 2.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1947 to Jan. 18, 1947 and that I last saw h.... alive on Jan. 18, 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury: Injured at work?

23. SIGNATURE: John H. Heaman M.D.
M. D. or Other
Address: 238 Camden Ave., Salisbury Date signed: Jan 18, 1947.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 00982

Reg. Dist. No. 383

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 25 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Lake St
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Mary D Franklin

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Ca	widow

6.(b) Name of husband or wife Henry D Franklin

6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) Mar about 1873

8. AGE: Years 74 about | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Berlin md (Town, county, and state)

10. Usual occupation Invalid Housework (When she worked)

11. Industry or business Same as above

FATHER 12. Name Unknown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Mrs Mary Woodland

Address Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 17-47 (month) (day) (year)

Cemetery or crematory Hanston

Location Salisbury md

18. Funeral director Juanita R Stewart

Address Salisbury md

19. 1/14 19 47 H. H. Harriet E Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/47 19 ... at 6.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-2-47 19 ... to 1-11-47 19 ...

and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death Uremia	9 days
Due to Arteriosclerosis.	2
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Robert Jane Long M. D. or other

Address Salisbury Md Date signed 1-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Evidence for the addition of date of death is shown on G 108 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

934 00983

Reg. Dist. No. 11

1. PLACE OF DEATH:
County Wicomico
City or town Delmar and Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Delmar Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Wesley Gandy

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife Nancy Gandy
6.(c) If alive, give age yes Dept know years

7. Birth date of deceased (mo., day, yr.) about 1861

8. AGE: Years	Months	Days	If less than one day
about 85	—	—	..... hrs. ..... min.

9. Birthplace Delmar Md Sid
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Same as above
12. Name of father John Gandy
13. Birthplace of father Delmar Md
14. Maiden name of mother James Jane
15. Birthplace of mother Delmar Del
16. Informant Emory Gandy
Address Delmar Md Side
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10-47 (month) (day) (year)
Cemetery or crematory Unman
Location Delmar Md
18. Funeral director James F Stewart
Address Salisbury Md
19. Jan. 10, 1947 (Date rec'd by registrar) Harry E Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1947, at 10 20 M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 1946, to Jan 7 1947
and that I last saw him alive on Jan 6 1947

Immediate cause of death	DURATION
Acute cardiac Dilatation	few hours
Due to Chronic Myocarditis & Nephritis	6 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G H Lynch M. D. or other
Address Delmar Del Date signed Jan 9 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195a

00984

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: Penin. Gen. Hospital Salisbury Md
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Girdletree. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Clifford Harmon
3.(b) Social Security Number: 217-07-3988

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Thelma E. Harmon
6.(c) If alive, give age: 41 years
7. Birth date of deceased (mo., day, yr.): May 30 - 1902
8. AGE: Years 44 Months 7 Days 26 If less than one day ... hrs. ... min.
9. Birthplace: Girdletree, Worcester Md (Town, county, and state)
10. Usual occupation: Timber Woods
11. Industry or business:
FATHER 12. Name: Norris Harmon
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ellen Rowley
15. Birthplace: Maryland
16. Informant: Thelma E. Harmon
Address: Girdletree, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29/47 (month) (day) (year)
Cemetery or crematory: Woolefords
Location: Girdletree
18. Funeral director: Clay E. Timmons
Address: Snow Hill, Md
19. 1/28, 1947 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1947 at 11:20 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...
Immediate cause of death: fractured ribs & fractured lumbar vertebrae — DURATION: 5 days
Due to: Log rolling on him
Due to:
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 1/21/47
Where did injury occur? Girdletree (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Log rolled on him Injured at work? Yes
23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other
Address: Snow Hill Md Date signed: 1/26/47

2-35

00985

Dr Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137a

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days and 16 1/2 hours

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 25 days and 16 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Delaware County Sussex

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 Grove
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Clarence Hearn

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Annie E. Hearn

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 16, 1842

8. AGE: Years	Months	Days	If less than one day
74			...hrs. ...min.

9. Birthplace Whitesville Del
(Town, county, and state)

10. Usual occupation Retired Conductor

11. Industry or business Penn. Railroad Co.

FATHER
12. Name Isaac T Hearne
13. Birthplace Whitesville, Del.

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs Katherine Taylor
Address Cleveland, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 - 28 - 44 (month) (day) (year)

Cemetery or crematory First Methodist

Location Delmar, Delaware

18. Funeral director W. S. Harvel Co.

Address Delmar, Delaware

19. 1/28, 19 44 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 19 44, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 44 to Jan 25 19 44

and that I last saw h... alive on Jan 25 19 44

Immediate cause of death Uremia — DURATION

Due to Hypertrophy, prostate

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Perineal hypertrophy prostate Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phyley A Insley M. D. or other

Address Salisbury Md Date signed 1-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

06986

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar Rural #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar Rural #3
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION) 70
2.(a) If veteran, name war

3.(a) FULL NAME: Robert E. Hearn

3.(b) Social Security Number: 221-03-2438

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beulah T. Hearn
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Dec. 10 - 1884

8. AGE:

Years	Months	Days	If less than one day
62	1	3	hrs. min.

9. Birthplace: Delmar Wicomico Md
(Town, county, and state)
10. Usual occupation: Mason
11. Industry or business

FATHER
12. Name: Marcellus E. Hearn
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Hastings
15. Birthplace: Maryland

16. Informant: Mrs Beulah T. Hearn
Address: Delmar, Del. Md. Rural #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16/47 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Pittsville, Md

18. Funeral director: Elay E Dennis
Address: Ardwell, Md

19. 1/15 1947 (Date rec'd by registrar) Bassett E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1947 at 12 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1947, to Jan 13 1947
and that I last saw h... alive on Jan 13 1947

Immediate cause of death	DURATION
Acute Cerebral Hemorrhage not	6 hrs
Caused Paralysis	
Due to Arteriosclerosis & aging	
20 years	few years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J H Lynch M. D. or other
Address: Delmar Del Date signed 1/16/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

00987

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address (if not) where death occurred: 634 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 634 W. Main St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Francis Asbury Fillman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel A. Fillman

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1875

8. AGE: Years: 71 Months: 11 Days: 22 If less than one day: ... hrs. ... min.

9. Birthplace: Quantico Md (Town, county, and state)

10. Usual occupation: Shirt Ironer

11. Industry or business: retired many years

MOTHER FATHER

12. Name: Asaiah Fillmyer

13. Birthplace: Wicomico Co. Md.

MOTHER

14. Maiden name: Maria Dickerson

15. Birthplace: Quantico Md

16. Informant: Mrs. Ethel A. Fillman

Address: 634 W. Main St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 15-47 (month) (day) (year)

Cemetery or crematory: Parsons Mem.

Location: Salisbury Maryland

18. Funeral director: Hillman & Walter R. Hillman

Address: Salisbury Maryland.

19. 1/16-1947 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13th 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/13 1947, to 1/13 1947.

and that I last saw him alive on 1/13/47 1947

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. R. Grange M.D. M. D. or other

Address: Salisbury Md. Date signed: 1/13/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14a

CERTIFICATE OF DEATH

06988

Reg. Diat. No. 3350

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

San Domingo

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Floretta M. Hopkins

3.(b) Social Security Number 222-07-3822

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Hollis Roberts

6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) September 9, 1919

8. AGE:

Years	Months	Days	If less than one day
27	3	25	....hrs. ....min.

9. Birthplace Camden New Jersey (Town, county and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Thomas Tingle

13. Birthplace New Jersey

MOTHER 14. Maiden name Lelia Thorogood

15. Birthplace New Jersey

16. Informant Willard W. Hopkins

Address Mardela Springs, Maryland, R.F.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 8, 1947 (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J.K. Trumpton and Son

Address Federalsburg, Maryland

19. 1-8 1947 (Date rec'd by registrar) Walter G. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1947, at 7:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1947, to Jan 4 1947 and that I last saw h.. alive on Jan 4 1947

	DURATION
Immediate cause(s) death Child birth:	
Due to Ruptured Uterus	
Due to Caesarean operation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.S. Kuhlman M.D. (M. D. or other)

Address Sharptown Md Date signed 1/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00989

Reg. Dist. No. 3890

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 2 Hrs. 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Railroad Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel Albert Huntington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 7th 1946

8. AGE: Years | Months: 5 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: P. B. Hoyt. Salisbury Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

12. Name: Raymond Isaac Huntington

13. Birthplace: Salisbury Maryland

14. Maiden name: Nina Clapetta Morgan

15. Birthplace: Crisfield Maryland

16. Informant: Mr. Raymond I. Huntington
Address: Railroad Ave. Delmar Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan: 20, 1947 (month) (day) (year)
Cemetery or crematory: Charity Church Cem.
Location: near Salisbury Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 1/20 19 47 Received by (registrar): Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 1947, at 3 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 19 47 to Jan 16 19 47 and that I last saw him alive on Jan 16, 19 47

Immediate cause of death: Bronchopneumonia

DURATION

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. V. Sohler M. D.
M. D. or other
Address: Delmar Md Date signed: 1-16-47

dr. moyer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06990

Reg. Dist. No. 330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 33 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel R.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: James Mrs Sallie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James W. Elbert

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): June 12, 1889

8. AGE:

Years	Months	Days	If less than one day
57	7	8	✓ hrs. ✓ min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Housework Housewife

11. Industry or business: ✓

FATHER
12. Name: Samuel Rogers
13. Birthplace: Delaware

MOTHER
14. Maiden name: Annie Tarbut
15. Birthplace: Delaware

16. Informant: J Elmer James
Address: Laurel Del R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23 47 (month) (day) (year)

Cemetery or crematory: Odd Fellows Cemetery

Location: Laurel Delaware

18. Funeral director: Harvey C Williamson

Address: Federalsburg Md

19. 1/23/47 (Date rec'd by registrar) Harold E. Thomas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1947 at 7:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1946 to Jan 20 1947 and that I last saw h... alive on Jan 20 1947

Immediate cause of death	DURATION
(1) Diabetes Mellitus	
(2) Diabetic Acidosis	
Due to (3) Dissecting Aneurysm of abdominal aorta.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas M. Moyer MD M.D. or other

Address: Laurel Del Date signed 1/24/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

00991

CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Eden
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, Institution, or street address where death occurred: RD #2
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Eden
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RD #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel James Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Kizzy Jones
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 10 or 1869

8. AGE:

Years	Months	Days	If less than one day
77	7	4	hrs. min.

9. Birthplace: near Fruitland Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER
12. Name: William Jones
13. Birthplace: near Fruitland Md.
MOTHER
14. Maiden name: Hettie Jones
15. Birthplace: near Fruitland Md.
16. Informant: Mrs. Burton Lody
Address: Eden Md. RD. #2
17. Burial, cremation, or removal. Which?: Buried
Date thereof: Jan. 17 1947
(Month) (day) (year)
Cemetery or crematory: Fruitland Cem.
Location: Fruitland Md
18. Funeral director: Hillman & Walter R. Hillman
Address: Salisbury Maryland.
19. (Date rec'd by registrar): 1/15 1947
Registrar: Harriet L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14 1947, at 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/10 1947, to 1/17 1947
and that I last saw him alive on 1/13 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. R. Grange M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 1/17/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00992

CERTIFICATE OF DEATH

Reg. Dist. No. 3930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life in this County

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 E Road St
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME John P Lewis

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a-a	Married

6.(b) Name of husband or wife Mamie A Lewis

6.(c) If alive, give age (Don't know) years

7. Birth date of deceased (mo., day, yr.) about 1870 years

8. AGE: Years	Months	Days	If less than one day
about 76	—	—	...hrs. ...min.

8. Birthplace Somerset Hill md
(Town, county, and state)

10. Usual occupation Farmer for years

11. Industry or business Same as above

FATHER
12. Name Henry Lewis
13. Birthplace Somerset Hill md

MOTHER
14. Maiden name Georgiana Lewis
15. Birthplace Somerset Hill md

16. Informant Hattie Lewis
Address Salisbury md

17. Burial Date thereof Jan 29 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glass Hill

Location Parsonsburg md

18. Funeral director James H Stewart

Address Salisbury, Md

19. 1/31/1947 Carrie L Lewis Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1947, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1946 to Jan 25 1947

and that I last saw h[illegible] alive on Nov. 27 1946

Immediate cause of death	DURATION
Cardiac Failure	
Due to Myocarditis (Chronic)	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Stan M. D.

Address Salisbury, Md Date signed 1-29-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

00993

CERTIFICATE OF DEATH

Reg. Dist. No. 0830

1. PLACE OF DEATH: County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 8 years; Hospital, institution, or street address where death occurred: R.D. #2. Quantico Road; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); Street No. R.D. #2. Quantico Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mava Murray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife William John Murray

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) March 10-1868

8. AGE:

Years	Months	Days	If less than one day
78	10	14	...hrs. ...min.

9. Birthplace Allen Maryland (Town, county, and state)

10. Usual occupation at Home

11. Industry or business

FATHER — 12. Name William John Bounds

FATHER — 13. Birthplace Allen Maryland

MOTHER — 14. Maiden name Esther Hastings

MOTHER — 15. Birthplace Allen Maryland

16. Informant Mrs Linwood Dashe

Address R.D. #2. (Quantico Road,) Salisbury Md

17. Buried (Burial, cremation, or removal? Which?) Date thereof Jan. 27-1947 (month) (day) (year)

Cemetery or crematory Allen Church Cem

Location Allen Maryland.

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury Maryland.

19. 1/25 1947 Harriet J. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24th 1947 at 8. P. M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1947 to Jan 24 1947

and that I last saw him alive on Jan 22. 1947

Immediate cause of death	DURATION
Cerebral hemorrhage.	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas A Tinsley M. D. or other

Address Salisbury Md Date signed 1-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a

00994

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 205 W. Pikes, ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest M Nichols

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Margaret Nichols 6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): June, 7, 18

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	7	13		

9. Birthplace: Wicomico co Md (Town, county, and state)

10. Usual occupation: R.R. Representative

11. Industry or business: Penna R.R.

FATHER 12. Name: Levin Thomas Nichols

FATHER 13. Birthplace: Sussex co. Del

MOTHER 14. Maiden name: Henrietta Perdue

MOTHER 15. Birthplace: Wicomico co. md

16. Informant: Mrs E. M. Nichols

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22-47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

18. Funeral director: The Hill & Johnson Co

Address: Salisbury, Md

19. 1/23, 19 47 The Hill & Johnson Co Registrar (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1947, at 6 20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Jan. 20 1947

and that I last saw h. alive on Jan. 19 1947

Immediate cause of death	Interval between onset and death
Acute Myelogenous Leukemia	4 month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: David J. Gilmore M-D. M. D. or other

Address: 501 N. Division Salisbury Date signed: Jan. 20 1947

1-35

06996

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164c

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County Wicomico
City or town Fruitland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: R.D.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Fruitland (If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Wicomico Co. (If rural give LOCATION)
2.(a) If veteran, name war Army serial #20-342-804 Tec. 5 Grade 488 th O.C.C. Disc. July 9-45

3.(a) FULL NAME Roy Franklin Perdue
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Margaret Perdue
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feb. 19-1908
8. AGE: Years 38 Months 10 Days 16 If less than one day ... hrs. ... min.
9. Birthplace R.D. Salisbury Md. (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business
FATHER 12. Name Elwood Perdue
13. Birthplace Wicomico Co. Md.
MOTHER 14. Maiden name Anna Wootten
15. Birthplace Sussex Co. Delaware
16. Informant Mrs. Margaret Perdue
Address R.D. Fruitland Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7-1947 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland
19. 1/7, 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5th 1947, at 4:20 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical Examiner ... 19..., to ... autopsied 19...
and that I last saw h... alive on ... 19...
Immediate cause of death Gunshot wound of head — DURATION 40 minutes
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations None — Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide — Date of 1/5/47
Where did injury occur? Eden, Wicomico, Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Shot himself — Injured at work? no
23. SIGNATURE for Rademaker MD. Deputy Med Exam. — M. D. or other
Address Salisbury Md — Date signed 1/5/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0095

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland, County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James H Phillips

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Clora L Phillips

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Nov 9 1876

8. AGE: Years: 70 | Months: 2 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Whitesville Del (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

MOTHER

12. Name: Sarah Ellen Elliott

13. Birthplace: Del.

FATHER

14. Maiden name: James Spicer Phillips

15. Birthplace: Del.

16. Informant: Mrs Clora L Phillips

Address: Willards Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1947 (month) (day) (year)

Cemetery or crematory: Pine Church Cemetery

Location: Near Gumboro, Del.

18. Funeral director: M. Pasha Watson

Address: Selbyville, Del.

19. (Date rec'd by registrar) 1/28/47 Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1947 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1946 19 to Jan 27 1947 19 and that I last saw h[illegible] alive on 1-21-47 19

Immediate cause of death	DURATION
Carcinoma of prostate gland	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank R. Lewis M.D. (M. D. or other)

Address: Willards Md. Date signed 1-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. One correct entry is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 924

CERTIFICATE OF DEATH

00997

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 531 S. Division St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 531 S. Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Lee Porter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hattie or Esther Porter
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 29-1867

8. AGE: Years: 79 | Months: 0 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Allen Maryland
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Farmer

FATHER 12. Name: Robert J. Porter
13. Birthplace: Allen Md.

MOTHER 14. Maiden name: Amanda Bradshaw
15. Birthplace: Allen Md.

16. Informant: Mrs. Hattie Porter
Address: 531 S. Div. St. Salisbury Md.

17. Burial, cremation, or removal. Which?: Buried
Date thereof: Jan. 8-1947 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. (Date received by registrar): 1/8/1947 Harriet L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3rd 1947 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. - 1946 to Jan-3 1947 and that I last saw h[illegible] alive on Jan 3 1946

Immediate cause of death: Valvular Heart Disease — DURATION: unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas R Mann M. D. or other
Address: Salisbury Md. Date signed: 1/4/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92 d

00998

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec. 26, 1946

Hospital, institution, or street address where death occurred: Salisbury, Md. E. S. Tuberculosis Sanatorium

How long in hospital or institution? Since Dec. 26, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sheppard, William Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

B.(b) Name of husband or wife: Helen Sheppard

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): June 30, 1876

8. AGE:

Years	Months	Days	If less than one day
70	6	6	...hrs. ...min.

9. Birthplace: Buckingham County, Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER

12. Name: Samuel Jones Sheppard

13. Birthplace: Virginia

MOTHER

14. Maiden name: Mary Penlleton

15. Birthplace: Virginia

16. Informant: self

Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof 1/9/47 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Dana D. Burbage

Address: Berlin Md

19. (Date rec'd by registrar) 1/9/47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 19 47 at 3:15p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 26 19 46 to Jan 6 19 47

and that I last saw h... im alive on Jan. 6 19 47

Immediate cause of death	DURATION
Decompensated Arterio-sclerotic heart disease	
Due to: with mitral regurgitation	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Shen M.D. M. D. or other

Address: Snow Hill, Md. Date signed: 1/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

CERTIFICATE OF DEATH

00999

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: 305 Charles Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arabella Shockley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Hezekiah H. Shockley 6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) March 4 - 1860

8. AGE:

Years	Months	Days	If less than one day
86	10	9	hrs. min.

9. Birthplace Pittsville Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Benjamin Fokey
13. Birthplace Worcester Co. Md.

MOTHER
14. Maiden name Peggy Ford
15. Birthplace Worcester Co. Md.

16. Informant Mrs. George Ardis
Address 305 Charles St. Salisbury Md.

17. Buried (Burial, cremation, or removal? Which?) Date thereof Jan. 16 47 (month) (day) (year)
Cemetery or crematory Parsons Mem.
Location Salisbury Maryland

18. Funeral director Hellen Mort. Co. Walter R. Hellen
Address Salisbury Maryland

19. 1/16/47 (Date rec'd by registrar) Carrie L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944, to Jan 13 1947
and that I last saw h.e.r. alive on Jan 13 1947

Immediate cause of death	DURATION
Acute cardiac failure	
Due to Chronic myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles A. Insley M. D. or other
Address Salisbury Md. Date signed 1-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 3370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Wicomico County
City or town White Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Duration
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico Co
City or town Wicomico White Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jenette Smiley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1947

8. AGE:

Years	Months	Days	If less than one day
-	0	0	3½ hrs. ..... min.

9. Birthplace White Haven
(Town, county, and state)

10. Usual occupation -

11. Industry or business none

FATHER
12. Name Willis Smiley
13. Birthplace Shorptown Md.

MOTHER
14. Maiden name Emily Hart
15. Birthplace White Haven

16. Informant Willis Smiley
Address White Haven, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1 12 1947 (month) (day) (year)
Cemetery or crematory White Haven Cem
Location White Haven Md.

18. Funeral director Booker M. Veach
Address 404 Lake st. Salisbury Md.

19. 1/12 (Date rec'd by registrar) 1947 R. Wolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-9-47 19.. to 1-9-47 19..
and that I last saw h- alive on 1-9-47 19..

Immediate cause of death Cerebral Hemorrhage — DURATION 3½ hrs.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Stone M.D.
M. D. or other
Address Hebron Md. Date signed 1-13-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

CERTIFICATE OF DEATH

01001 333

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

Fruitland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucy Emma Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Louis A. Smith

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1885.

8. AGE: Years	Months	Days	If less than one day
61	4	2	hrs. min.

9. Birthplace: Wicomico Co. Maryland. (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: Elijas Townsend

13. Birthplace: Wicomcio Co. Maryland.

MOTHER — 14. Maiden name: Emma Williams

15. Birthplace: Wicomico Co. Maryland.

16. Informant: Mr. Louis A. Smith

Address: Fruitland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/ 19/47 (month) (day) (year)

Cemetery or crematory: Fruitland Church Cemetery

Location: Fruitland, Maryland.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Maryland.

19. 1/19, 19 47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 19 47 at 10.15 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	sudden death
Due to: Chronic Myocarditis	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Rademaker MD Deputy Med. Examiner M. D. or other

Address: Salisbury, Md. Date signed: 1/16/47

2-35

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. An exact statement of occupation is very important. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01002

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.G. Hoyt
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 212 Race Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Tarr Jerry Wayne

3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept. 5-1946
8. AGE: Years — Months 4 — Days 21 — If less than one day ... hrs. ... min.
9. Birthplace P.G. Hoyt, Salisbury Md. (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Wilmer E. Tarr
13. Birthplace Worcester Co. Maryland

MOTHER
14. Maiden name Billie Louise Luce
15. Birthplace Graham Texas

16. Informant Mr. Wilmer E. Tarr
Address 212 Race st. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29-47 (month) (day) (year)
Cemetery or crematory Smullen Cemetery
Location St. Luke Worcester Co. Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland
19. 1/27, 1947. Harriet A. Johnson Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1947, at 6 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... and that I last saw h... alive on ... 19... medical examiners certificate

Immediate cause of death	DURATION
acute pneumonitis	12 hrs
Due to	
Due to	
Other conditions Enlarged Thymus	unknown

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE La Rademaker MD Deputy Med Examiner M. D. or other
Address Salisbury, Md Date signed 1/26/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

CERTIFICATE OF DEATH

01003

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: 105 Cherry Street

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Emma Jane Taylor

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: George M. Taylor

8.(c) If alive, give age ..... years Dead

7. Birth date of deceased (mo., day, yr.): Dec. 19-1864

8. AGE: Years 82 Months 0 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace: Fruitland Maryland (Town, county, and state)

10. Usual occupation .....

11. Industry or business: at Home

FATHER 12. Name: Thomas Powell

13. Birthplace: Powellville Md.

MOTHER 14. Maiden name: Mary Ann ——

15. Birthplace: Unknown

16. Informant: Mrs. Beatrice I. Bolich

Address: 501 Rightus Mill Road Narkets Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13-1947 (Month) (day) (year)

Cemetery or crematory: Fruitland Cem.

Location: Fruitland, Maryland

18. Funeral director: Holloway & C. Walter R. Holloway

Address: Salisbury Maryland.

19. 1/13/1947 Received by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10 1947 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3 1947 to 1/10 1947 and that I last saw her alive on 1/10 1947

Immediate cause of death: Arteriosclerosis & Chronic myocarditis. — DURATION

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Fred L. Gramse M.D. M. D. or other

Address: Salisbury, Md. Date signed 1/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01064 3730 170C

Reg. Diat. No. 460

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Peninsula Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester

City or town Snow Hill.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Thomas Davis Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1882

8. AGE: Years 64 | Months 4 | Days 27 | If less than one day hrs. min.

9. Birthplace Accomac County (Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name Jaccob Taylor

13. Birthplace Virginia

MOTHER 14. Maiden name Margaret Taylor

15. Birthplace Virginia

16. Informant Thomas H. Taylor Jr

Address Snow Hill, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1-26-47 (month) (day) (year)

Cemetery or crematory Fairfield

Location Snow Hill, Md.

18. Funeral director William H. James Jr.

Address Princess Anne, Md.

19. 1/27/47 (Date rec'd by registrar) L. T. Johnson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 19 47 at 9.20 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19

and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Fractured Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/19/47

Where did injury occur? Rt 13 Somerset Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury struck by auto Injured at work? No

23. SIGNATURE Henry M. Lankford MD

M. D. or other

Address Princess Anne Md Date signed 1/20/47

Deputy Medical Examiner for Somerset County

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 518

01005

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 515 S. Division St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md., County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 S. Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sherman Gardner Waller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie M. Waller
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Nov. 25th 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	1	20		

9. Birthplace: Sussex Co. Delaware
(Town, county, and state)
10. Usual occupation: Custodian Employed by
11. Industry or business: City of Salisbury Md.
FATHER 12. Name: William H. Wallace
13. Birthplace: Sussex Co. Delaware
MOTHER 14. Maiden name: Sarah E. Love
15. Birthplace: Sussex Co. Delaware
16. Informant: Mrs. Nettie M. Waller
Address: 515 S. Division St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17th 1947 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland.
18. Funeral director: Holloway & Co. Walter K. Holloway
Address: Salisbury Maryland.
19. 1/17/47 (Date rec'd by registrar) Bessie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15th 1947, at 2.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1947, to Jan. 15, 1947, and that I last saw him alive on Jan. 13, 1947

Immediate cause of death	DURATION
Carcinoma of the Prostate	approx. 1 year.
Due to	
Due to	
Other conditions: Carcinomatosis	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of the Prostate
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Charles W. Trader M.D.
M. D. or other
Address: Salisbury, Md. Date signed: Jan. 16, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01006

Reg. Dist. No. 3890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula Hospital

How long in hospital or institution? 3 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wic.

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ocean City road Salisbury
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: White, Mrs. Cora

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Salisbury Md. Elmer C White

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1878

8. AGE:

Years	Months	Days	If less than one day
68	2	7	...hrs. ...min.

8. Birthplace: Bridgeville Sussex Del
(Town, county, and state)

10. Usual occupation: Household duties

11. Industry or business: At Home

FATHER
12. Name: Lauren Fitch
13. Birthplace: Del

MOTHER
14. Maiden name: Sina Lacy
15. Birthplace: Del

18. Informant: Elmer White
Address: Ocean City Rd. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2 1947 (month) (day) (year)

Cemetery or crematory: Bridgeville Del.

Location: Bridgeville Cemetery

18. Funeral director: H. C. Hardesty & Son

Address: Bridgeville, Del.

19. 2/1 1947 Received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15th 1946 to Jan 30 1947 and that I last saw h... alive on Jan 30th 1947

	DURATION
Immediate cause of death: Pneumonia	
Due to: Nephritis	
Due to: Heart Failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

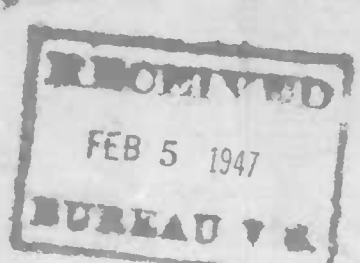
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Carrie J Hearn M. D. or other

Address: 203 W Church St Date signed: 2/3/47

Miss Turner
Registrar of
Sales Dist



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01046

932

CERTIFICATE OF DEATH

Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico.

City or town Nanticoke.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alonza B. Willey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	5	..... hrs. ..... min.

9. Birthplace Nanticoke (Town, county, and state)

10. Usual occupation Oysterman

11. Industry or business

FATHER 12. Name John T. Willey

13. Birthplace Nanticoke, Md.

MOTHER 14. Maiden name Sarah Messick

15. Birthplace Nanticoke, Md.

16. Informant Ada Jones

Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/47 (month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Jesterville, Md.

18. Funeral director C. G. Messick

Address Bivalve, Md.

19. Feb 3 1947 (Date rec'd by registrar) R. Bedford Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11, 1947 to Jan 30 1947

and that I last saw h... alive on Jan 30 1947

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr.
Due to Chronic Myocarditis.	2
Due to Hypertension C-V-D.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Stone. M. D. or other

Address Nanticoke, Md. Date signed 2-3-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

01007

CERTIFICATE OF DEATH

Reg. Diat. No. 330

1. PLACE OF DEATH:

County: Wicomico Co.

City or town: Mardela. —
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Mardela
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1½ mile Mardela Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Sally Jane Weider.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col.	Widow

6.(b) Name of husband or wife: Harrison Weider

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb. 10 1888

8. AGE: Years	Months	Days	If less than one day
58	10	28	— hrs. — min.

9. Birthplace: Quantico, Wicomico Co. Md.
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: None

FATHER
12. Name: Wesley Dale
13. Birthplace: Wicomico County.

MOTHER
14. Maiden name: Mary Dale
15. Birthplace: Wicomico Co. Md

16. Informant: Nettie Williams

Address: Quantico. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 11, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Nebo Cemetery

Location: Near Shanktown, Maryland

18. Funeral director: J. J. Frampton & Son

Address: Fredericksburg, Maryland

19. 1/10/47 (Date rec'd by registrar) 19 W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 8th 1947, at 1.30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20th 1946 to Jan Dec. 31st 1946 and that I last saw h.. alive on Dec. 31 1946

Immediate cause of death	DURATION
Paralysis	
Due to Diabetes for 1 year or more.	
Due to High Blood Pressure	
Due to Surgical Cause of death	
Other conditions Paralyzed 8 days	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank R. Dunn M. D. or other

Address: Mardela, Md. Date signed: Jan. 8. 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

01008

CERTIFICATE OF DEATH

Reg. Diat. No. 989

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 19 hrs. 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1512 N. Division Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Cora Wright

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: E. L. B. Wright

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1881

8. AGE: Years	Months	Days	If less than one day
61	10	29	...hrs. ...min.

9. Birthplace: Queenstown, Queen Anne, Md (Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER — 12. Name: David S. Downs

FATHER — 13. Birthplace: Kent Del

MOTHER — 14. Maiden name: Elvina Milbourne

MOTHER — 15. Birthplace: Kent Del

16. Informant: Mr. E. L. B. Wright

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/47 (month) (day) (year)

Cemetery or crematory: Parson Cemetery

Location: Salisbury Md

18. Funeral director: The Hill & Johnson Co

Address: Salisbury Md

19. 1/24 1947 (Date rec'd by registrar) Harriet E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19... to Jan 22 1947 and that I last saw h... alive on Jan 22 1947

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: J. W. Wanner M. D.

Address: Salisbury Md. M.D. or other. Date signed Jan 22 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35